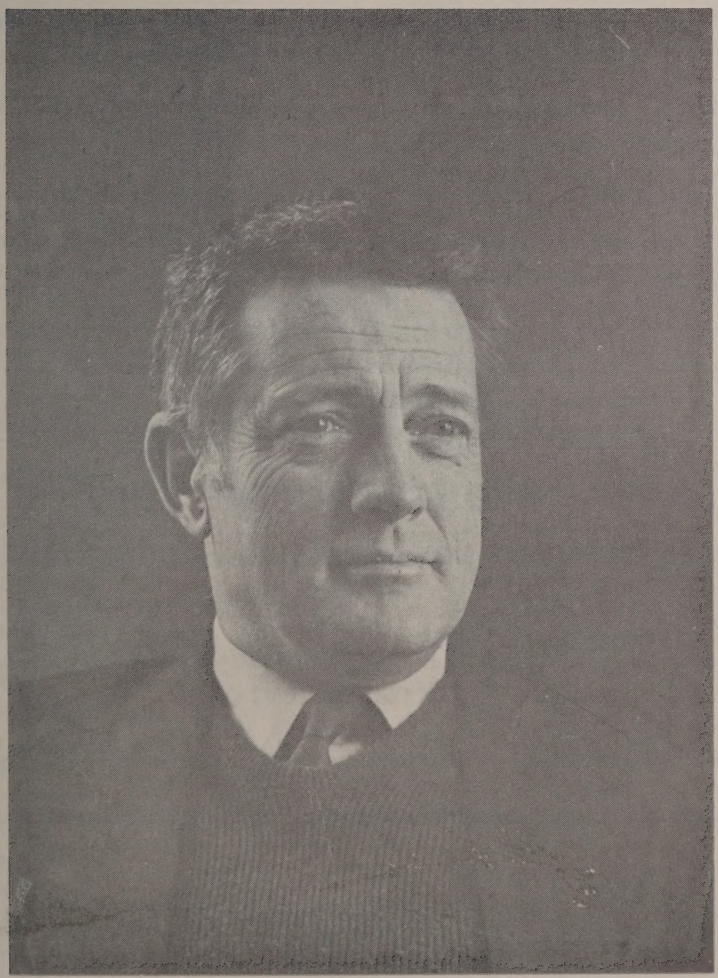
# The Hampden Hippocrat

MAY
1975



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VOL. XXXI, NO. 5 MAY 1975

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The official bulletin
for The Hampden District
of The Massachusetts
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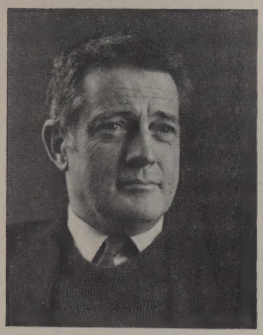

# Your President's Page

## Pull Together

Fellow Physicians;

My message to you as I enter into this year as president of the Hampden District Medical Society is, "Pull together."

We have watched the erosion of the usual and customary aspects of medicine and are living in a time of great change, confused goals, and constant encroachment of what we have maintained for years was our freedom of practice.

I am not writing to defend or deny the changes we are presently seeing, but rather to say that because of these we need to create better understanding among ourselves so that we can "pull together" both as physicians group-wise and also as health services area-wide.

We are now faced in this area with the new governmental monolith, the revised B agency, the health planning group for Western Massachusetts that through new federal state regulations will have greater participation and control of the health care industry. The scope of its services and its participation in our lives has not yet been clarified but the law as written is very concerned with both health man power and also health care delivery.

Many of us have participated in our sister organizations, The Healthcare Foundation of Western Mass. and its allied corporate structure, Region 1 P.S.R.O. As originally written, this organization was to have become control effective by January 1, 1976.

We have also seen the encroachment by the state welfare department, through its surveillance program called CHAMP, in the freedom of our practice and perhaps in the delivery of medical care. Many of us have learned to live with this program that has been brought forth and it will depend in the future on what the thrust of the program will be as to how we can live with it over the long haul.

There have also been other invading organizations including the "Blues" who would like to exert more control over the independent non-profit hospital and the practicing physician through increasing involvement in peer review and financial control. Also the joint commission on accreditation has an increasing determination to retain its "place in the sun" by increased vigilance particularly in the area of chart review and physician monitoring and accreditation concepts. More

(NEXT PAGE PLEASE)

*To look up and not down, to look forward and not back, to look out and not in, and to lend a hand.*

Edward Everett Hale
"Ten Times One Is Ten" 1870

and more there have been independent actions taken by boards of directors of hospitals as they become increasingly aware of their liabilities and responsibilities as corporate boards. Consumers also, that person that the whole industry is centered around, have been made more aware and are becoming more positive in their feelings concerning their personal rights and privileges.

We come to the most urgent problem of all, that being of malpractice which was so ably discussed by Dr. Bloom in March in the Hippocrat. We must find a solution very soon as the problem becomes more stark in its reality with each passing day.

With all of these external pressures it is no wonder that we see physicians confused, critical and worrying about their relationship to hospital staffs and to their peers. Now we sense, in the district medical society offices, the feeling that the men are unsure about the future and are worried as to whether there will be any protection for them as the future unfolds.

And so as we continue down this road I could only suggest that there still is The Hampden District Medical Society, your organization, the place where you have a voice if you will only exercise that voice,the place you have the availability of information and help if you will but participate.

As late as five years ago, I was a non-participant also but found that through participation and active involvement on my part I have not felt as alone and as threatened as I think I might have felt had I not become more active in the organization. So as I say let's all pull together over the ensuing years to create a better, more unified, more effective medical society and health care industry.

Gardner Cox, II, M.D.

"Let's choose executors and talk of wills."

Act III, Richard II
William Shakespeare

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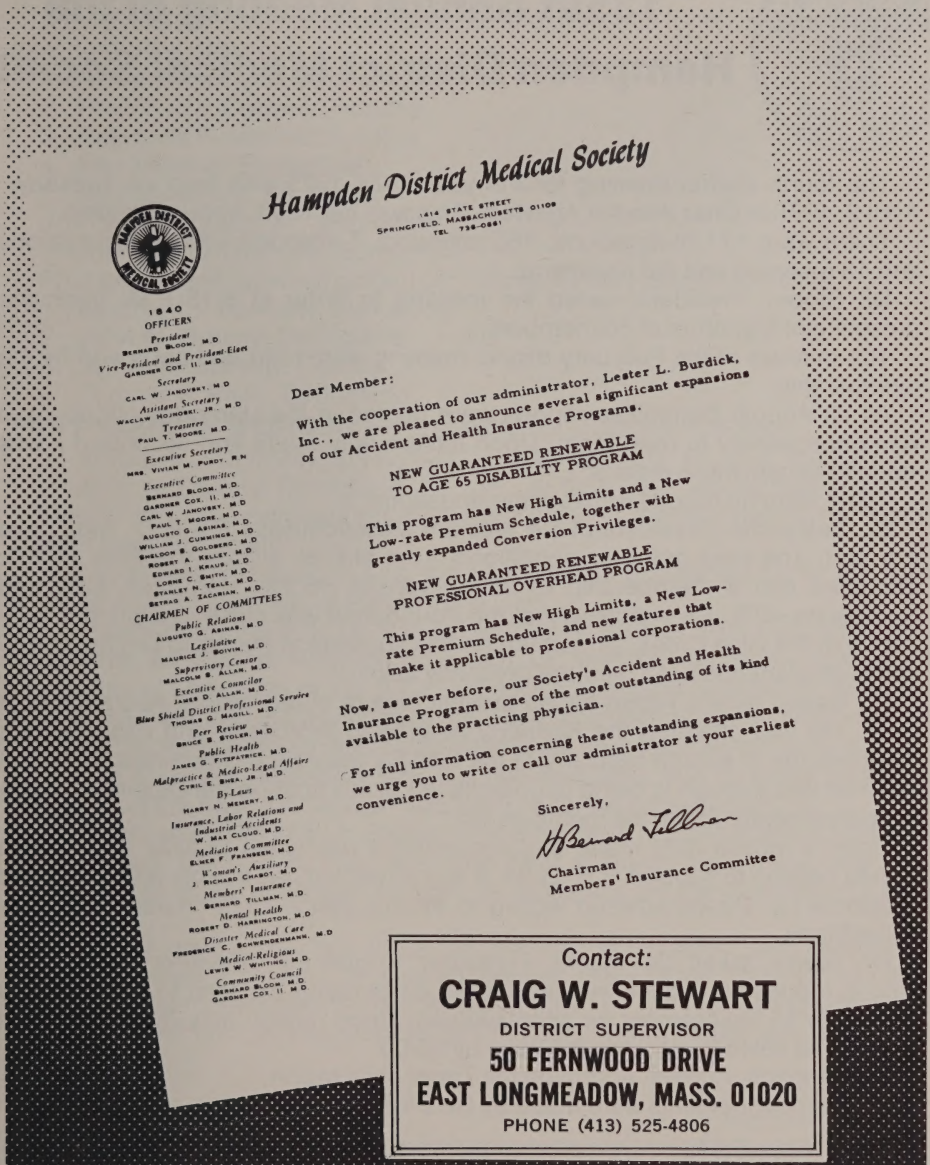

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# 135th Annual Meeting of the Hampden District Medical Society

The fourth district meeting for the year 1974-1975 was held on Tuesday, April 2, 1975 at Chez Josef in Agawam. This was the 135th Annual Meeting.

There were 171 reservations, 165 attended, 7 attended without reservations and 13 reserved and did not attend.

Dr. Bloom, President, called the meeting to order at 6:15 P.M. upon the presence of a quorum of 50 members.

The minutes of the February district meeting were read and approved by the membership.

As all Annual Committee reports were printed in the Hampden Hippocrat it was unnecessary to read them. Upon motion duly made and seconded it was voted to accept these reports.

There were no reports with recommendations.

Dr. LaMarche, President of the Western Massachusetts P.S.R.O., Inc., gave a report. The next grant for conditional from H.E.W. will be the local PSRO. Berkshire has a membership of 90%, Franklin 86.3%, Hampden 52% and Hampshire 40%. He indicated that the Foundation was close to signing a contract with the Blue Cross. Dr. LaMarche has application blanks to join the PSRO and invited anyone not a member presently to join.

Dr. Dasco gave a report on the present picture of the liability insurance program. He had attended the Kennedy hearing in Worcester and has attended the meetings in Boston regularly of the Liability Insurance Committee. He is not satisfied that enough is being accomplished at this time on the state level. More support is needed from the membership.

Upon a motion duly made and seconded it was voted to write and send a signed petition to support H.B. 2098. If any physician has trouble with insurance problems Dr. Dasco advised writing to the Insurance Commissioner, Mr. Michael Stone.

Dr. Bloom asked Dr. Moore, Treasurer, to give the Treasurer's report. Dr. Moore requested a dues increase of $5.00 bringing the total to $85.00 ($80 dues with $5 assessment for scholarships). Upon motion duly made and seconded it as voted to increase the dues by $5.00.

Dr. Simpson, Auditor, approved the Treasurer's report.

Two announcements were made by Dr. Bloom.

*ANNOUNCEMENTS*

A HDMS Golf Day, July 23, 1975 at Wyckoff Park Country Club in Holyoke

Springfield-Mercy Hospital Golf Day—June 11, 1975 at Springfield Country Club.

Dr. Harry Roberts, Chairman

(CONT. NEXT PAGE)

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There being no business the meeting was adjourned for the social hour.

A delicious roast beef dinner was served promptly at 7:30 P.M.

After dinner, Dr. Bloom asked for a moment of silence for physicians who had died during the past year.

1. Arthur J. Horrigan, Springfield
2. Raymond J. Conway, Holyoke
3. Raymond R. Meunier, Ludlow
4. Max Millman, Springfield
5. Max Bovarnick, Springfield
6. Frank J. Jordan, Jr., Wilbraham
7. John H. Fitz-Gibbons, Springfield

Four physicians received golden certificates for 50 years in medicine:

1. Ambrose J. Connelly, Springfield
2. John W. Greany, Springfield
3. James M. Murphy, Palmer
4. Thomas F. Reilly, Springfield

**FIFTY YEARS IN MEDICINE**—Presentation of Golden Certificates

1. Ambrose J. Connelly, Springfield
2. John W. Greany, Springfield
3. James M. Murphy, Palmer
4. Thomas F. Reilly, Springfield

Twenty-two new members received certificates of membership in Hampden District Medical Society.

A plaque was presented to Mrs. Barbara Pitoniak of Channel 22 for her help in giving news in the medical field to the public.

The speaker for the evening was Dr. Sidney H. Wanzer from Concord, Massachusetts, an Internal Medicine physician. Dr. Wanzer was also a member of the House of Delegates of the AMA. He spoke about the benefits of membership in the AMA and the workings of the AMA. The various committees such as the Medical Service Committee of the AMA work very hard for the benefit of the individual physician. Massachusetts has five delegates, one for every thousand members of the AMA. Dr. Wanzer was thanked for his presentation.

Dr. Sears was asked by Dr. Bloom to give the slate of officers and councilors for the years 1975-1976. (See attached) After a motion duly made and seconded it was voted to accept the slate as presented by the Nominating Committee.

Dr. Bloom gave a brief talk about his past year as President, and introduced Dr. Cox, the new President. Dr. Cox announced some of the Chairmen of committees. He then presented Dr. Bloom with a gavel for his year as President and complemented him on the success as President. The meeting was adjourned at 9:30 P.M.

Vivian Purdy
Executive Secretary

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**Indications:** This combination drug finds its usefulness primarily in the treatment of edema. Any usefulness of triamterene when used with a thiazide in hypertension will derive from its potassium-sparing effect. Either its main diuretic effect or potassium-sparing effect when used with a thiazide drug should be determined by individual titration. (See box warning.)

Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

**Contraindications:** Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

**Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

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# Executive Committee Highlites

The Executive Committee convened at 7 P.M. on Tuesday, April 15, 1975.

Present were Drs. Bloom, Moore, Cummings, Janovsky, Goldberg, Zacarian, Smith, Asinas, Teale, Kelley, Hojnoski, Cox and Mrs. Purdy.

The minutes of the March 13, 1975 meeting were reading and approved as read.

Mr. Tuveson, Administrator of the Wesson Memorial Hospital gave a report of the lack of a contract between Blue Cross and five hospitals of Western Massachusetts. This report was informational to the Executive Committee. Mr. Tuveson was thanked for his presentation.

Dr. Navazio was present to answer questions on his report on Long Range Planning. Further study is required.

*CORRESPONDENCE*

1. A notice had been sent from The Center for Technological Alternatives about April 17, 1975 being named "Food Day," a day of concern and action on the food crisis, emphasizing prices, hunger and diet. This was informational.

2. Dr. Keenan wrote asking for support of H.B. #593 relating to an act providing for indemnity payments to subscribers of a medical service corporation under certain circumstances. This will be announced at the District Meeting.

3. Mr. Ciciarelli, general agent of the Mutual of Omaha wrote suggesting that Lloyds of London may be able to help in the present liability crisis. A letter will be written to Mr. C. accepting his offer.

*OLD BUSINESS*

As an answer to an old problem, relating to physicians on hospital payrolls, the Attorney General's office stated that this is a matter for private counsel.

Dr. Asinas studied a pamphlet brought by Dr. Bloom from the National Leadership Conference on communications media guidelines. This will be printed for use by the members.

*NEW BUSINESS*

All Annual reports are printed in the Hampden Hippocrat. There are no resolutions to be voted upon. The Executive Committee approved the reports.

Dr. Moore gave the Treasurer's report. Upon motion duly made and seconded it was voted to accept his report.

A letter to the Editor written for the Springfield Republican by someone on the Malpractice issue was answered by Dr. Bloom. This is informational.

Mrs. Purdy gave a report of a notice served to some physicians from the Attorney General's office. This was informational.

The Mediation committee asked the Executive Committee to review two cases. One was a complaint against a physician who was not a member. This case will not be considered.

Dr. Sears, Chairman of the Nominating Committee wrote calling attention to the by-law relating to vacancies of certain offices and committees. The Executive Committee accepted this as informational.

Governor Dukakis answered Dr. Bloom's letter relative to having a physician as the Commissioner of Public Health. Governor Dukakis still is of the opinion that the Commissioner does not have to be a physician.

The meeting was adjourned at 10:15 P.M.

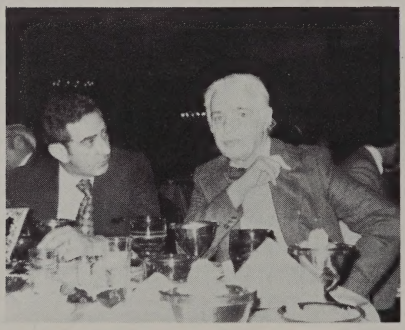
Respectfully submitted,

Carl W. Janovsky, M.D.
Secretary

# Photo Hilites from the Annual Meeting

SOME OF THE OLD AND SOME OF THE NEW OFFICERS

AN THIS FELLOW SAID TO THE OTHER FELLOW, "SAAY HE SAYS"



PART OF THE ARMENIAN CONTENGENT – TWO GOOD DOC'S –

LET'S SEE, WHAT SHOULD I DELETE? THE HOUR IS LATE!

THANK YOU DOCTOR! 50 YEARS OF DEDICATION

B NATURAL – FROM THE PRESIDENT'S SWAN SONG

# THE PAGE OF THE HDMS'S WOMAN'S AUXILIARY

Wake up people! The hand writing is on the wall. We are being squeezed out of our basic freedoms.

Nowhere were the truth of these statements more evident than at the first joint meeting of the Women's Auxiliary to the Mass. Medical Society, the Council of Voluntary Services and the Mass. Hospital Association, held on April 18, at the Marriot Hotel in Newton.

The picture is very grim indeed. The subject of medical liability is an all too familiar one. The expectations and demands from the public are highly unrealistic. Physicians are miraculous healers with a panacea for all ills.

It is vitally important that we educate the public of what can and can not be accomplished in the practice of medicine. The media of TV, newspapers, etc., have contributed to the movement of emotionalism and over simplification of medicine. Why couldn't we use the media as our useful tool in bringing the public back to reality and establishing an understanding of health care. It seems nowhere in the world is medicine so advanced and so little appreciated.

Many proposals have been discussed to resolve the malpractice situation. Among them are a medical tribunal, consisting of a judge, a physician and a lawyer. This would establish a screening process in order to determine whether there was evidence of medical malpractice. This would contribute to decreasing the number of suits and awards. Also there is talk of requiring the posting of a heavy bond by the plaintiff. If his case was lost, he would automatically lose this bond. This would help to discourage the abuse via the present court system. Another proposal is to form a medical discipline board. Other points considered are binding arbitration which would result in taking suits out of the jury system. A medical injury compensation board and establishing a catastrophic clause entered in insurance policies. However there has as yet been no attempt made to control the contingency fee system for attorneys or establishing a cap on the amount awarded as presently allowed.

Legislation may be a two edged sword. Improper controls by the government could result in a compromise of good health care. More and more the government is thrusting itself between the physicians and patients.

It is necessary to know our legislators and for them to know us. Only by presenting the realities of medical practice and the present inequities can we prevent legislation arising out of misunderstanding and misinformation to be imposed on us that would not be desirable for the quality of health care we wish to maintain.

As we all know, quality cost money. There is no way the government can finance or contain health care costs. The result will be a rationing of health care services and the control of everyone in the health care industry. Consequently the industry will be reduced to mediocrity and totalitarianism.

What can we do as auxiliarians? Keep abreast of all health care bills. Write to your legislators supporting or opposing bills in conjunction with your Medical Society. Get involved, and encourage your husband's involvement to insure the rights and freedoms in the practice of medicine. We need team work. If we all participate we can be a strong force to enhance the quality of medical care for the patients of hard working and conscientious physicians with less unnecessary harassment.

Mrs. Robert Bye (Cynthia)

# Care, care and CARE or Orthopedics in a Developing Country

Garry deN. Hough, III, M.D.

**Part 2**

In last month's article I tried to give some of the background for the medical problems found in Indonesia, and some of the technical and cultural barriers facing an American who cares enough to do something about them. Since 1962 MEDICO has been the medical arm of the Committee for American Relief Everywhere. In accepting the staff support of CARE, the organization has maintained Dr. Tom Dooley's concept of personal service by concerned individuals. The mainstay of MEDICO's programs is the visiting consultant who spends one month "teaching and treating" in a coordinated program. Introduced to local idiosyncrasies by previous consultants, supported and guided by the local CARE staff, he adds his ideas and actions to the needs of the area, knowing that he will be followed by others of like mind. Because CARE is a non-governmental organization, it can promote an international effort, although its funds come primarily from donations from the United States and Canada. The Jakarta Orthopedic Training Program began in 1968 when there were only 2 civilian and 6 military orthopedists for 120 million people in Indonesia. The majority of the 83 previous consultants have been from Australia, whose participation in this and other Indonesian programs is facilitated by their geographic proximity. About one-third have come from America, and there have been representatives from Canada, Singapore, India and New Zealand. Although I sometimes wondered how anyone could learn anything with a new professor every month, nine men have been graduated, with seven more currently in training. The program is about to be phased over to local control, which is the goal of all MEDICO programs. Consultants will probably continue on an intermittent basis, but will no longer have primary training responsibility.

During my tenure, orthopedic teaching at the medical student level was entirely done by the Indonesians. Since all of the trainees were qualified general surgeons, little O.R. supervision was necessary, and was mostly handled by the Indonesian faculty or senior trainees. In fact my only operative participation in Jakarta was for my own edification, such as the surgical treatment of skeletal tuberculosis and some interesting bone and soft tissue tumors. My usual schedule consisted of clinical teaching, ward rounds, and a daily one-hour didactic lecture.

The primary orthopedic problems in Indonesia are tuberculosis and trauma. Most skeletal tuberculosis is treated by surgical debridement after a month of antibiotics. Simultaneous arthrodesis is performed in the spine and in adult cases where the joint is mechanically destroyed. In children, efforts are usually made to preserve motion in major peripheral joints.

The impact of mechanization on this pedestrian society is appalling. Motorcycles and motor scooters are an economic necessity and as destructive as they are in this country. The local bicycle taxis have a penchant for running into cars, trains, and even each other, with devastating results. Industrial safety is rudimentary. In most general hospitals 30 to 50% of the surgical beds contain orthopedic patients. The length of stay of these patients is seri-

(NEXT PAGE PLEASE)

ously increased by delays in requesting care, inadequate facilities for operative treatment, and the lack of familiarity of general surgeons with orthopedic methods. Paraplegia is a desperate problem. Nursing care adequate to prevent bedsores and urinary infection is available only in a few facilities, and even when rehabilitated, the paraplegic cannot live in an Indonesian village with its mud streets and squat toilets. A prosthetics capability is developing but there is still quite a backlog, and Western-designed prostheses don't work too well in rice paddies. Children's reconstructive surgery is just beginning, with fair treatment of polio residuals, elementary care for congenital encephalopathy, but no treatment for scoliosis.

There are many difficulties in introducing modern orthopedic techniques, even in Jakarta. X-ray evaluation is handicapped by unreliable voltage, outdated film, and aging developing solutions. Operative infections are common, due to poor isolation techniques, delay in treating compound fractures, and sometimes poor operative environment. Nursing care is poor due to abysmal wages, difficult working conditions and very low prestige value for the nursing profession. Laboratory support is limited, and intensive care is not available. On the other hand, there are more drugs and antibiotics available in Indonesia than there are in the U.S. Information on their effectiveness comes largely from detail men and is often not on a professional level. Drug combinations and shotgun therapy are still very popular.

CARE's programs recognize these difficulties and have made progress in spite of them. The orthopedic trainees are all men of known surgical competence, and are a sincere, hard-working, and personable group. They are developing techniques which are appropriate for the diseases prevalent in Indonesia and the conditions under which these diseases must be treated. At the same time, they are learning the areas in which improvements can be made. Most of them have already treated orthopedic patients during their general surgical practice, and are confident of their ability to work more effectively on their return to their communities. They don't know how to do total hips or reconstructive hand surgery, but they know far more about skeletal tuberculosis, unreduced dislocations of two years' duration, and smallpox arthritis (I saw two cases of this) than they would ever learn in the U.S. Except for their limited financial opportunities, the motivation for emigrating to a developed country has been successfully eliminated.

During my last month I moved to Solo, Central Java, a delightful city of one million people, set in the greenest volcanic valley I have ever seen. The medical conditions were even more primitive. There was only one shift of surgical nurses who did emergency duty without compensatory time off. Ster-

(OVER PLEASE)

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ile ward supplies were almost non-existent, and one of the hospitals was without running water. The emphasis here was service, supplied by a permanent CARE team of nurses, lab techs, a midwife and an anesthetist under the leadership of a Canadian general surgeon. Each was on a two-year contract, and although the pay was mediocre, travel allowances were included. I helped four Indonesian general surgeons do the orthopedic work in a 350 bed hospital. There was plenty to do. The CARE team had concentrated on upgrading the O.R. and establishing an intensive care unit, where good medical techniques could be demonstrated to doctors and nurses.

There are several other CARE programs operating in Indonesia, including nutrition education, school feeding, and agricultural assistance. All are accomplished with a combination of American money, internationally donated goods and services, and local assistance in supplies, housing, etc. The total value of the CARE program in Indonesia is about 2.7 million dollars a year. The actual cash coming from America to support this program is $557,000. The local staff is very proud of this multiplication effect which is achieved by the careful use of funds and a maximal use of donated goods and services and local government contributions. This economical use of resources is not apparent in other programs, notably those emanating from the United Nations. Although all assistance programs are subjected to frustrations, delays and inefficiencies, CARE personnel seem to overcome these more effectively. The statement that it is more blessed to give than to receive does not proclaim a directive, but states a psychologic fact. Handouts create jealousy, not friendship. But CARE seems to have developed a formula of concern, cooperation and self-help which not only promotes the welfare of developing countries but establishes individual and collective friendships at the same time.

I had a good time in Indonesia. There is no question I gained more than I gave, but one of the things I gained was a feeling of accomplishment. Never have I understood so well the meaning of the phrase "give 'til it feels good." I recommend a contribution to CARE of service, material or cash as an effective way to demonstrate your concern for the hungry and underprivileged.

Garry deN. Hough, III, M.D.

# In Memoriam

**John H. Fitz-Gibbon, M.D.**

Dr. John H. Fitz-Gibbon died Thursday, April 24, 1975 in Springfield.

A native of Holyoke, Dr. Fitz-Gibbon was a graduate of Providence College and Columbia University School of Dental and Oral Surgery. He graduated from Tufts University Medical School.

Dr. Fitz-Gibbon was a Plastic Surgeon in Springfield.

He was a member of the New England Society of Plastic & Reconstruction Surgery, the American Society Maxillofacial Surgery.

To his family, friends and associates the Hampden District Medical Society deepest sympathy is extended.

Vivian M. Purdy

# Featured Article:

# I Am An American

**The Response of Dr. I. B. Syed in Behalf of the New Citizens on April 10, 1975 at Symphony Hall, Springfield, MA**

*Featured Article:*
*The thoughts and opinions of a new citizen to our country, state, and county, he is calling the facts as he sees them. Perhaps some readers will disagree—but Dr. Syed does let us look into a mirror of self appraisal and some of the images are not pleasant—but should move us to action.*

Dr. Elliott, Mayor Sullivan, Distinguished Guests, Fellow Americans, Ladies & Gentlemen:

I am very proud and happy to be an American citizen. It is a pleasure to be here this evening to respond on behalf of the new citizens. At the outset I would like to thank Mr. Raymond E. Morrow, Director of Adult Education, and the Committee of "I Am An American Day" Celebration for giving me this opportunity.

I want to respond by answering four questions:

1. Why I came to the United States
2. Why I became a United States citizen
3. What is the present American Scene
4. What I want to do as a new citizen.

*Question 1:* The first exposure of United States I had was through watching Hollywood movies. As a young boy I was impressed and fascinated, watching such movies as "Thief of Baghdad" and "Jungle Boy" which starred the elephant boy, Sabu. Sabu was born and brought up in Mysore, which happens to be my state also. As a young boy I used to go to morning shows and matinees which were cheap and screened a lot of stunt movies, such as Flash Gordon, Superman and Batman.

I remember very well, when I was 6 or 7 years old that I walked to a movie theatre 3 miles away to see a Hollywood movie matinee. That evening I told my mother: "I wasted my money watching that dirty movie (Western Romantic) which showed nothing but hugging and kissing by men and women." (Kissing is prohibited in public in India.) I went to see thrills and fighting. I was disappointed.

As I grew, my taste changed and I used to watch many social, detective and mystery movies. I never used to miss the movies of Alfred Hitchcock. "Psycho" is the best suspense movie I have ever seen. "Peyton Place" is the best social film and I like it because its story is very near to Indian social life. I have watched movies made in countries all over the world including Russia, but believe me, nothing can

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match Hollywood. By watching Hollywood movies, I increased my knowledge of the United States culture, history and government, geography and scientific achievement.

The Voice of America was my favorite radio program. I was exclusively tuning in for scientific programs. I was little interested in the propaganda broadcasts by the United States Government.

When I was going to college in Bangalore, Mysore State, I utilized the numerous services rendered by the United States Information Library (USIL). I used to borrow freely a large number of text books on various subjects. I used to get free popular magazines from U.S.A. I used to get a free news weekly "American Reporter" published by the American Embassy in New Delhi. I used to watch movies at USIL on campus life in the different universities of U.S. and on the space programs and scientific achievements.

Many American professors were invited to give lectures in the USIL auditorium. USIL had all college catalogs and financial assistance information available for all prospective students. Going to the U.S. for higher studies has been considered by almost every Indian student as one of the greatest ambitions and achievements in life, and I was no exception. Watching in newspapers the photos of one or two students leaving Bangalore for higher studies in U.S. was a great stimulus and an impetus for my own efforts in that direction. To go to U.S. to obtain a doctorate became the single most important desire of my life.

Apart from the availability of scholarships, financial assistance to foreign students by the generous U.S., the most attractive thing to me was the system of education in U.S., which is highly advanced. Freedom to choose any subject and to study it at a time convenient to the student, the interdisciplinary approach, no age barrier, no long essay answers in the exams,

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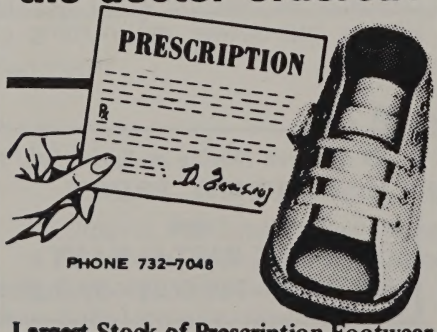


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the friendly relationship between the professors and the students are but a few of the many good points in the U.S. educational system. Where on earth can one find a physicist studying the basic medical sciences from anatomy to pathology and pharmacology along with the M.D. students except in the United States and particularly at the Johns Hopkins University.

*Question 2:* After having eaten the salt of U.S. for six years, becoming a citizen is an humble expression of gratitude to the people and government of the United States of America.

By becoming a citizen, I have fulfilled my commitment to the United States Public Health Service, which so generously financed my studies at the Johns Hopkins University and made me able to meet successfully any scientific challenge in the physical, biological or basic medical sciences.

I did not want to be left behind as an alien for decades or all my life. I had a sincere desire to become involved in the mainstream of American life. I did not want that unique and


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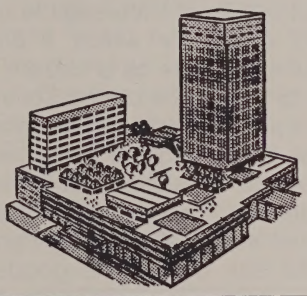

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golden opportunity to be denied to me simply because I am not an American citizen. I had bitter experiences of such denials on flimsy grounds of National Security, although there was no relation.

To compete for positions exclusively reserved for U.S. citizens, I am now able to do. Now I feel a liberated man and have peace of mind because nobody and nobody can discriminate against me because of my color, national origin, religion or sex. Now I have the great power to vote to elect the right person for the right job.

Furthermore, I will have the opportunity and privilege to work as a Juror. And last but not least I am eligible to hold public office for which I am suited. After nine years as a citizen, I am eligible to become a United States Senator. I have desires to hold the public office at the highest level, except that of the Presidency and the Vice-Presidency. If the people draft me and when they feel I am the right person, who can deliver the goods, I shall never decline the responsibility nor disappoint them!

*Question 3. The American Scene.*

The whole world knows that U.S. is the richest, the most powerful and technologically the most advanced and the leader of the world. This evening I want to show you another side of America—the darker side of my America.

To my new fellow Americans I could say: "America is no more the land of opportunity." It was in the past and it may be in the future, but not now. These are the troubles I see which need correcting by all of us. As President Ford said in his State of the Union address to the Congress: "The State of the Union is bad."

Today America has an energy crisis due to the short-sightedness, improper planning and irrational actions of our past leaders and our own selfishness. This will continue as long as the current priorities and policies are not changed. The economy is weakened by the high unemployment, recession and inflation. It is ironical to note that foreign capital and investment in this country are rejected to satisfy the wishes of a small section of the people.

Drug abuse is a powerful enemy of the United States. A foreign country could take over U.S. without firing a single shot, by simply making a sizable U.S. population of drug addicts. Because drug addicts are always looking for their high, they care less for patriotism, discipline, value of freedom, democracy, liberty and pursuit of happiness. It does not take a genius to predict that if drug abuse is not controlled, then it could lead to the decay and decline of these United States.

Crime and corruption exists from the lowest to the highest level in the country. Criminologists claim many causes for the crime, unequal justice,

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corrupt law enforcement, permissiveness, lack of parental guidance. To me decay of the American family is the single most important reason for the prevalence of drug abuse and crime in American Society today. Millions of American homes from poor to rich are beset by the disease of permissiveness, erosion of high ideals, lack of right leadership, lack of self-discipline, honest character, warmth, love and stability. Serious crimes including rape, indiscriminate use of guns, in our schools and streets could be traced to wrong parental values, parental apathy, or other wrong influences. In my former country, if somebody's child goes astray the society literally spits on the faces of the parents for having failed to take care of their children. They say: "You are not dogs that give birth to a litter in one street and run away to another street. You must discharge your responsibility as parents." Conversely, parents get the credit for the achievements of their children. We should encourage the strengthening of our family unit. First in homes, next schools, we should develop an early consciousness of high moral values, right character and discipline.

The surest way to promote a criminal society is to make sure crime pays. Tragically in America it pays frequently. Like almost every other institution the United States criminal justice system has been slowed down, become seriously crippled and even blind. The Agnew case, the Watergate scandal, Nixon pardon are living testimonials of injustice partially rectified by our law.

The surveillance by Intelligence Agencies on we citizens make me doubt that the Bill of Rights is truly for all and the functioning of the United States Constitution is hampered. Is U.S. making a mockery of Democracy? Is this the Republic for which the founding fathers so gallantly fought and sacrificed their lives? Is this still the Republic whose Constitution was written in such a flowery language with heart-touching ideals of freedom, liberty and pursuit of happiness? Is this the free country which attracts freedom-loving people from the communist, socialist, capitalist and other third world countries? Yes it is! But we must fight to preserve these ideals.

There is nothing pathetic to me than seeing the plight of our senior citizens. The elderly poor often go hungry or they eat pet food, they are mugged and killed. They are exploited by profiteers in nursing homes, allegedly

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headed by men high in religious circles. Is it necessary for the elderly to die unattended in nursing homes? Human dignity, decency and thantology dictate that a dying person be allowed to keep his or her hand in the hand of a near or dear one. Fellow Americans, remember one day everyone will become old. Is this what you want to happen to you? I shall never allow this to happen to me. I shall use my new powers as a citizen to change the system. Honor thy father and mother.

Another mockery in this land of free enterprise is the "Fair Trade Act" practiced in 36 states. This is blatant day robbery of the consumers. Any laws made should be in the public interest, public safety and consumer protection. The Fair Trade Act needs to be rewritten. The standard of health in this great nation could be improved. There is no dearth for cases of V.D. and T.B. Leprosy, malaria, typhoid are not rarities. Unless some type of national health insurance comes, the standard of health may not be improved. The existence of T.B. in America was a big surprise to me.

It is ironical to note that U.S. has supported and is supporting dictatorial regimes throughout the world. But what I strongly opposed was the sending of young Americans by drafting them into the military against their wishes to fight an undeclared and hence an illegal war. A war—guerilla war—for which they are not trained, to fight in a land 12,000 miles away—a land strange and unfamiliar, in a hostile tropical climate with plenty of malaria and cholera germs to greet them. The power of the will of the people to fight is more powerful than the Atom Bomb or Hydrogen Bomb.

When U.S. fought its War of Independence 200 years ago, no country drafted its youngsters and sent them here to fight for U.S. It was the will of the people to fight and the moral and effective leadership of the founding fathers which led to the independence of U.S.

*Question 4:* To make America a better place to live we should restore discipline in every family and school. Thus making a society which respects the law.

To avoid drug abuse by their children, parents must realize drinking of coffee, tea, cola beverages, smoking of tobacco products, alcohol are all drug abuses which can lead to serious drug abuses and narcotics. Parents should set their own example to their children. As the twig is bent, perhaps a return to the turn of the century.

Schools must enforce discipline on students. They should have the children memorize selected poems of great poets, they should memorize multiple tables from 1 to 20. This will eliminate more dependence on electronic calculators and gives self-reliance and confidence in oneself.

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Amend the constitution to prevent repetition of the Watergate Scandals. Remember Nixon proved checks and balances of the Government to be ineffective. Had he burnt the tapes, there would have been no evidence to impeach and convict him.

We must make our country greater by our character and will power. Not by possessing deadly weapons, including weapons of chemical, biological warfare which make the lands of Southeast Asia uninhabitable for 50 years to come.

"If wealth is lost, nothing is lost. If health is lost, something is lost. If character is lost, everything is lost."

When I visit a foreign country the people of that country should receive me as a citizen of the great country of U.S. with warmth, admiration, affection and friendliness, and not as "Watch out, he may be a CIA Agent."

– FINIS –

Ibrahan B. Syed, Ph.D.

Commentary:

My sincere acknowledgements to Mr. Demetres and Ms. Mary Zavala for my indepth knowledge of the United States Constitution and Government.

To Congressman Boland for accelerating the process of my citizenship.

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# A Statement

**From the Co-Chairman of the Ad Hoc Committee on Professional Liability Presented at the Hearing of the Senate Health Subcommittee St. Vincent's Hospital Worcester, Mass.**

Mr. Chairman, Members of the Committee:

My name is Demosthenes D. Dasco, I am a board certified neurosurgeon, and have been in practice in Springfield, Massachusetts, for ten years. I work as a member of the Neurosurgical and Neurological Group with three other neurosurgeons and two neurologists.

The present system of handling medical malpractice lawsuits, has been abused and deteriorated to the point that it is now considered a national crisis. Many casualty insurance companies have abandoned the medical liability field because of losses. The medical specialties hardest hit are anesthesiologists, neurosurgeons, orthopedic surgeons and obstetricians. Insurance companies have served notice to many doctors that insurance will be unavailable at any price. We have been proclaimed an ininsurable risk and have been compared to floods and earthquakes.

Ten years ago medical malpractice law suits were rare and a neurosurgeon paid four hundred dollars for insurance. Today, in this state, a neurosurgeon pays four thousand six hundred dollars. Since 1973, the premium rate has increased two hundred fifty per cent, and it continues to

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rise rapidly. In the state of New York the proposed annual premium for a neurosurgeon has been set at forty two thousand dollars starting on July 1st, 1975.

Under the present circumstances, it has become extremely difficult for a young doctor to go into practice and many older physicians are considering early retirement.

The number of law suits against doctors during the last four years have risen at an alarming rate. Paradoxically, this happens at a time when we have superior medical technology, improved training of physicians and impressive strides in the surgical field.

Another irony is that the competent and better trained physicians are those sued more often as proven by statistics.

As a result of this crisis the physicians are now practicing defensive medicine. A great deal of money is spent daily for unnecessary x-rays, expensive tests, consultations, and extra days of hospitalization. Fear of possible law suit forces the doctors to defend themselves by ordering those extras which can be used to their advantage in case of a court trial. Furthermore, high risk patients are being refused treatment by "defensive" physicians. We now live in an atmosphere where the patient is looked upon as an adversary or a future plaintiff.

Your efforts to reduce expenses related to health care, are doomed to fail unless the fear of malpractice is reduced to more normal or reasonable levels.

It is obvious that in the end the public is suffering and the public is paying the bill. Have no doubt, this is not only the doctor's problem, it is the public's problem. As of necessity the doctors fees and the rates charged by hospitals have to reflect this rise of expense for insurance.

The solution to the problem is not only availability of malpractice insurance. For a real solution to this problem we need two very basic changes in the present system. First we need to set a limit or a reasonable ceiling to the liability of the physician or the awards granted by juries. Second, and more important, we need to get the medical malpractice cases out of the jury court system. The average juror does not understand the complex and highly specialized medical problems in which, most often, there is difference of opinion even among doctors. Furthermore, emotional fac-

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tors usually play an important role in the decision of the jury. The jurors know that the doctor carries insurance.

In the present system, physicians lose even when they win a malpractice law suit because it costs insurance companies an average of fifteen thousand dollars per case for legal fees, depositions, expert witnesses, etc. This expense is passed on to the doctor through premiums and inevitably is passed on to the public. The plaintiff patient receives only 25% of the award, the rest goes for legal fees and expenses.

Arbitration by a panel of experts consisting of qualified lawyers, physicians and laymen will serve justice better and it will be less expensive than a trial by jury. Furthermore, it will dispose claims much faster than the present system.

I urge you to give this matter top priority realizing that it is of great concern to the general public. I repeat, this is not only the doctors problem, it is the publics problem as well!

Respectfully submitted,
Demosthenes D. Dasco, M.D.

Ed.'s Note: Drs. Bye and Dasco had given of themselves to assist us with our professional liability problems. They need your help. Please write to your state and federal representatives. Each letter is counted as an aye or nay. You have the ability to influence in an affirmative way. Write!

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# Editorial:

## The Reviewing System—

### A Step in the Right Direction?

On the 29th of April, in the capacity of a member of the Executive Committee of the Western Massachusetts Hospital, I had the distinct pleasure of listening to Dr. Harry M. Lowd review the results of his survey for accreditation of that hospital. The outline of his presentation follows in abbreviated form but it does serve well by providing some solid guideons for we practicing physicians. Public Law 92—603 which is administered by the Department of Health, Education and Welfare, provides review of health care through two major mechanisms, a) Utilization review monitors the *costs* of the delivery systems and b) Peer Review monitors the *quality* of the delivered care. The Joint Commission for Accreditation of Hospitals has adjusted its surveys and standards to help the medical staff and the hospital to meet HEW's regulations stemming from PL 92—603. His critique led to these brief thoughts.

If a physician will assume a positive approach to these reviewing systems, he will find (and hopefully agree) that his patients will benefit and although his "paper work" is increased, ultimate cost effectiveness should be sharpened. All of us do not relish Big Brother's all seeing eye, we all are sure we are giving our patients the best in quality and keeping low or containing costs, yet the functioning reviewing systems are revealing that other physicians and other hospitals do identify inefficiencies and less than ideal quality care performances. Medicine and health care delivery is moving out of its horse and buggy and Cottage status into a progressive industrial status—the **new medicine.** With the adoption of modern industry's techniques and methodologies there will be difficult and, to some, painful times ahead. When the economy permits the institution of National Health Insurance this force will provide the final stabilization and the financial muscle to guarantee the best medical care for all the citizens at predictable and fiscally feasible costs. A proper balance will be achieved.

As long as physician reviews physician and provides the means for administration to review its costs, we have little to fear from the change in status. Should we fail to adapt, should we only drag our feet to attempt to stop or slow the New Medicine, should we not become involved in our internal housekeeping and policing problems then we invite non-physician control. As concerned physicians we must not take a defeatist attitude to these revolutionary (?) changes in status and delivery systems. Our leadership, as well as the rank and file, must provide the ideas for changing, modifying and redirecting those processes and changes which do not benefit patient, hospital or self. We must indicate those concepts which do improve the delivery system and contain cost because we will be both consumer and provider, our taxes will be underwriting the NHI system.

(NEXT PAGE PLEASE)

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Some would believe, that cost containment is synonymous with reduced income for physicians. The dramatic rise in physicians' incomes which followed the institution of Medicare and Medicaid was not physician caused but is attributable to poor actuarial estimates of utilization and resultant costs; this will not be repeated with the impending National Health Insurance system. The built in cost containment features will probably reduce the percentiles of payment and extra income will be derived from increased productivity i.e. seeing more patients per day. Those patients will be there, since access to care and physician will not be stymied by lack of dollars in the wallet or pocketbook. For a while the change in status will be hard on "good ole Doc," but he-we will survive. Corner cutting and streamlining daily procedures will be necessary for some, but again the peer review system will provide guidelines of equality and fairness. Our fifty hour work week should not be in jeopardy. The experience gained now with utilization review will provide the economists with the data to develop reimbursement formulaes. Again physician input into both U.R. & P.R. is essential, mandatory and good common sense.

To this physician, the reviewing systems are a proper step in the right direction. We are in the infancy of the age of the New Medicine, in which medical and health care is delivered by a complex team of medical and paramedical personnel directed by the physician. Much of what is and/or can be done for a patient no longer needs the hand or mind of the physician; guidelines for care can be followed by any properly trained individual. The physician, because of his training and knowledge, is however the logical individual to coordinate, to evaluate, to redirect, to plan the health care system schema. The legislators and the judges will have to write and codify the new laws necessary to pass on the physician's responsibilities to his paramedical associates. The current professional liability hassle is just the tip of the iceberg in this area! Yet this, too, will be settled through active or ongoing and retrospective review teams. The practice of medicine is a constant review—it is not new or foreign to our daily practices. With the New Medicine the concept is extended to larger groups and institutional practices, with the techniques and knowhow of modern business practices. The Capri and the Skyhawk have replaced the horse and buggy and modern administrative methods and trained personnel have replaced the nurse-administrator in the hospital management team. It's 1975!

The Editor-in-Chief

Ed's note: Your comments pro & con are hereby solicited.

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## PUBLIC LAW 92—603—Dr. H. M. Lowd's Outline
## HEW Administered, PSRO

### Cost Containment

Utilization Review
1. Admission documentation in 24 hours
2. Length of Stay—assigned numbers
3. Cost-misuse of supportive services
   One patient review and concurrent

### Quality Maintenance

Peer Review
1. Priviledges commensurate with training and ability
2. Annual reappointment policy will check physical, mental and medical abilities
3. Require proof of CME
4. Physician audit with disease review
   Retrospective and with groups of patients

### Patient Care Evaluation and Audit

Management Criteria
  Indications & Contraindications
    (Being developed for local usage)

Outcome
1. Admission
2. Diagnosis
3. Length of Stay
4. Mortality Rate
5. Discharge Condition
6. Complications with critical care

When outcome matches standards no problems, but when not so then need management review by physicians.

Does admission have a standard match with symptoms and studies? Have exceptions compatibility with resultant subdiagnoses?

Most hospitals are using JCAH system, which provides all necessary data for PSRO Utilization reviews.

Weakness of staff can be reviewed and improved via properly directed educational staff meetings.

The Credential committee holds the key to proper policing of physicians and can admonish by not renewing staff privileges.

When the hospital's quality care review system is good the PSRO will not interfere to impose its utilization review schema.

The JCAH's requirements are identical with HEW's peer review system.

### Criteria For Review used by JCAH & HEW

1. Use criteria developed by medical staff
2. Measurement of performance-Record room review (only 10% will vary)
3. Evaluate rejects—5% will be justified and 5% not so—Needs M.D. review
4. Elucidate corrective measures—Education to one or many
5. Reassessment to determine if corrective measures worked
6. Accountability of both physicians and hospital
7. Disciplinary actions taken
8. Listing of who notes results of audit and review
   a. Chairman of department
   b. Executive Committee
   c. Chief Executive Officer of Hospital
   d. Public via Governing Board or Medical Affairs Committee of Trustees

These criteria should be carried out four times a year and with four different disease categories.

If this has been done, the hospital and its medical staff will easily quality for a good utilization review and peer review.

# Quality of Professional Services

**Approved by the Board of Commissioners, April 1974**

## Standard

The hospital shall demonstrate that the quality of care provided to all patients is consistently optimal by continuously evaluating it through reliable and valid measures. Where the quality of patient care is shown to be less than optimal, improvement in quality shall be demonstrated.

## Interpretation

The quality of patient care shall be evaluated by members of the medical and other professional staffs directly responsible for patient care. Evidence of the quality of patient care provided in the hospital shall be demonstrated by measurement of actual care against specific criteria. These criteria must be established or adapted by the medical staff for evaluation of all physician-directed care, and by nonphysician health care professionals for evaluation of those aspects of patient care which they provide. Criteria must be explicit and measurable, and must reflect the optimal level of care that can be achieved through current medical and related health-science knowledge.

Because of the probable relationship between the quality of patient care and the outcome which the patient experiences as a result of intervention by physicians and other health care professionals, criteria shall include expected patient outcomes, such as health status at discharge, complications, mortality, morbidity, and demonstrated knowledge of the patient concerning his health status, level of functioning, and self-care after discharge. Criteria reflecting desirable processes of care should be used when it has been demonstrated that observed patient outcomes fail expectations; when the critical patient outcomes are long delayed; when medical intervention cannot, or can only marginally, affect patient outcomes; when specific diagnostic or therapeutic processes are known to affect directly patient outcomes, or when it is known that certain processes may result in the early detection or prevention of potential complications or chronic disabilities. Criteria also shall include validation of the diagnosis and, where appropriate, justification for hospital admission, surgery, and/or the use of specialized, hazardous drugs or procedures. Criteria may take into account specific patient variables such as health status prior to hospitalization, but these must be explicitly stated.

The measurement of the quality of patient care shall contribute to the reliability of the evaluation process. Since the patient medical record is the primary source of actual practice information, it must be accurate and complete. It must describe the patient's status at the time of admission, the care provided to the patient, his progress, and his health status at the

(NEXT PAGE)

# J.C.A.M. Standard

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time of discharge. To provide an unbiased measure of patient care, the number of medical records used in an evaluation study must be representative of the patient care being provided by all physicians and other health care professionals. The methods used for retrieving, abstracting, and reporting data from patient medical records shall assure the reliability of the data.

Variations from the established criteria shall be identified and justified. In actual practice, variations from criteria are often fully justified, but evidence for such justification must appear in the patient medical record and the reason for justification must be explicitly stated by the professionals evaluating care. Such justification may include patient variables such as health status prior to the time of medical intervention. Variations that are not justified to peer satisfaction must be analyzed. If analysis indicates inappropriate patterns of patient care, action must be taken to correct problems. Such action should be specific to the problem and may include educational or training programs, amended policies or procedures, increased or realigned staffing, provision of new equipment or facilities, or adjustments in staff privileges.

To demonstrate that corrective action has been effective, follow-up studies must be completed. If a problem poses a threat to patient health or safety, the follow-up must be immediate and should continue until it is clearly demonstrated that the problem has been corrected. If identified problems represent less-than-optimal patient care but are not immediately threatening to patients, follow-up must be completed within a reasonable period of time.

The entire patient care evaluation activity must be documented and its results reported. The general findings of and specific recommendations from evaluation studies conducted by the medical staff must be reported to the executive committee, the chief of the medical staff, the chief executive officer, and the governing body. The findings and recommendations from evaluation studies conducted by nonphysician health care professionals must be reported to the chief executive officer, the governing body, and the chief of the medical staff.

The evaluation activity shall be continuous and shall be comprehensive of the conditions and problems treated and the procedures performed. Evaluation studies shall be either ongoing or repeated periodically, according to the criticality of the evaluation study topic and of the problems previously disclosed. Evaluation criteria shall be revised or updated to reflect the findings of previous studies, new medical and health care knowledge, improvements in techniques, and scientific advances.

The results of the quality-of-care evaluation shall be specifically reflected in other quality-protective functions of the medical staff, including reappointment and reprivileging of medical staff members, control of the utilization of the hospital and its resources, the continual monitoring of practice within the professional staffs, and provision of continuing professional education.

JCAH Standards

*Ed's Note:* The above explanation of the JCAH Standards for Quality of Professional Services was furnished by Dr. Lowd. The clarity of the standard's interpretation bears wider distribution. It is so done with Dr. Lowd's permission.

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# Letter to the Editor:

**CHAPTER 766**
**Preschool Registration and Screening Program**
**May 19 thru June 3, 1975**

To the Editor:

In compliance with the Massachusetts Law Chapter 766 all children entering Public or Parochial schools in September 1975, will undergo various screening procedures and require a comprehensive physical examination prior to entering school. The Springfield Public Schools will conduct screening programs at each public elementary school at a scheduled time during the weeks of May 19, May 26 and on June 1, 2, & 3. All neighborhood children entering either public or parochial schools are to be screened. Screening procedures will include:

1. Vision
2. Hearing
3. Speech
4. Cognitive
5. Developmental
6. Psychological

During this same period the Health Department Nursing Staff will conference with the parent to:

1. Obtain a medical history
2. Determine where a comprehensive physical will be obtained prior to entering school. Emphasis as in the past will be placed on the family physician accomplishing this requirement.
3. Obtain an immunization record

The comprehensive physical is required to include an examination per the Massachusetts Department of Public Health Form PH M—18 (A form will be given to the parents during the city wide screening program.) Any physician who would like an additional supply may do so by calling the Health Department 781-0200 Ext. 228.

Any immunizations administered by the physicians' office is to be included on the record.

Any child who is required to have activities limited should have Form PT—60 completed. This will also be given to parents.

Whenever possible a child with a specific or special need should be brought to the attention of the Health Department or the School Department so that any early referral may be made for a proper educational planning program for the child.

John C. Ayres, M.D., M.P.H
Commissioner of Public Health

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**Contraindications:** Patients with known hypersensitivity to the drug.

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**Precautions:**

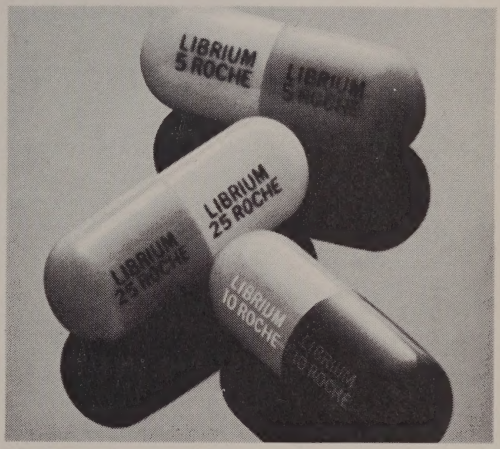
ORAL: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six.

INJECTABLE: Keep patients under observation, preferably in bed, up to three hours after initial injection; forbid ambulatory patients to operate vehicle following injection; do not administer to patients in shock or comatose states; use reduced dosage (usually 25 to 50 mg) for the elderly or debilitated and for children age twelve or older.

ORAL AND INJECTABLE: Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating compounds such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Please see following page.

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**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral: Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

*For Parenteral Administration:* Should be individualized according to diagnosis and response. While 300 mg may be given during a 6-hour period, do not exceed this dose in any 24-hour period. To control acute conditions rapidly, the usual initial adult dose is 50 to 100 mg I.M. or I.V. Subsequent treatment, if necessary, may be given orally. (See Precautions.)

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